CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LDING	01	COMPL	
		155752	B. WIN			10/03/2	U11
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
MODNIN	CODE NUBEINO A			1	BAILEY AVE		
		AND MEMORY CARE CENTER			I BEND, IN46637		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
K0000							
110000							
	A Life Safety	Code Recertification	K(0000			
	_	nsure Survey was					
		the Indiana State					
	_	Health in accordance					
	with 42 CFR 4	103.10(a).					
	g	10/02/11					
	Survey Date:	10/03/11					
	Facility Numb	er: 004732					
	Provider Numl	ber: 155752					
	AIM Number:	200808300					
	Surveyor: Ric	hard D. Schade, Life					
	Safety Code S	· ·					
	Safety Code S	pecialist					
	At this Life So	ifety Code survey,					
		•					
	•	Nursing and Memory					
		as found not in					
	compliance wi	th Requirements for					
	Participation in	n					
	Medicare/Med	licaid, 42 CFR					
		0(a), Life Safety from					
	-	000 edition of the					
	National Fire I						
		NFPA) 101, Life					
	`	, ,					
		LSC), Chapter 18,					
	New Health C	are Occupancies and					
LABORATOR	Y DIRECTOR'S OR PROV	TIDER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6DZ921

Facility ID:

004732

If continuation sheet

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ILTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155752	A. BUIL	DING	01	COMPL 10/03/2	
		100702	B. WING		DDDEGG CVENT CONTROL CONTROL	10/03/2	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE BAILEY AVE		
MORNINGSIDE NURSING AND MEMORY CARE CENTER					BEND, IN46637		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG			+	IAG	Dia leiner,		DATE
	410 IAC 10.2.						
	construction are sprinklered. To south wing, was 1952 with the state of 1962. The enteremodeled in 2 New construct a fire alarm syndetection in the spaces open to facility has a consultative a census of 36 survey. Quality Review by For Code Specialist-Medical Compliance with a forementione.	facility was be of Type V (111) and was fully The original building, as constructed in north wing added in ire building was 2005 and opened as ion. The facility has stem with smoke e corridors and the corridors. The capacity of 40 and had at the time of this Robert Booher, Life Safety dical Surveyor on 10/13/11.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155752 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 18325 BAILEY AVE	
B. WING 10/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE)11
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
MORNINGSIDE NURSING AND MEMORY CARE CENTER SOUTH BEND, IN46637	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROUBERRY NAMES CONDUCTION	(X5)
PREFIX (FACH DEFICIENCY MIJST BE PERCEDED BY FILL PREFIX (EACH CORRECTIVE ACTION SHOULD BE C	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
K0029 SS=E Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 34 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 2 doors to the main corridor serving hazardous areas closed and latched to prevent the passage of smoke. This deficient practice could affect any residents, visitors and staff in and near the kitchen. Findings include: Based on observations with the maintenance supervisor on 10/03/11 at 2:55 p.m., one of two doors to the kitchen lacked a mechanism to close and positively latch the door to the door frame. The maintenance supervisor acknowledged the problem at the time of observation. 3.1-19(b)	10/28/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUM		IDENTIFICATION NUMBER:	A. BUILDING 01			COMPL	COMPLETED	
		155752	1	B. WING 10/0		10/03/2	10/03/2011	
NAME OF PROVIDER OR SUPPLIER MORNINGSIDE NURSING AND MEMORY CARE CENTER			·!	18325 E	ADDRESS, CITY, STATE, ZIP CODE BAILEY AVE I BEND, IN46637			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	E ACTION SHOULD BE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE	
K0050 SS=F	varying conditions shift. The staff is f is aware that drills routine. Responsi conducting drills is competent person exercise leadershi conducted betwee announcement ma audible alarms. Based on reconsinterview, the ensure fire drill quarterly on earliest 4 quarters practice could staff and visitor emergency. Findings inclusionable alased on review in the properties of the staff and visitor emergency. Findings inclusionable alased on review in the properties of the properti	s who are qualified to p. Where drills are in 9 PM and 6 AM a coded ay be used instead of 18.7.1.2 rd review and facility failed to lls were conducted ach shift for 1 of the ach shift for 1 of the are ffect all residents, for s in the event of an de: ew of the facility's rds and interview on 40 p.m. with the upervisor, there was second shift fire drill parter of 2011. The	K	0050	K050 - The facility will ensur that fire drills are conducted quarterly basis in accordance life safety code standards. Adrills have been reviewed for compliance in accordance wilife safety standards. Drills we conducted in the future to me requirements as outlined in L safety code standards. Rest drills will be reported to the Committee at least monthly for months until problem is considered resolved. The facing requests paper compliance for resolution of this issue.	on a e with all will be eet alfe alts of DA or 3	10/28/2011	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155752	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/03/2011
NAME OF PROVIDER OR SUPPLIER MORNINGSIDE NURSING AND MEMORY CARE CENTER			STREET 18325	ADDRESS, CITY, STATE, ZIP CODE BAILEY AVE H BEND, IN46637	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K0143		the fire drill was not ing the third quarter			
E S S	wherein patients a treated by a separ 1-hour fire-resistive. (b) in an area that sprinklered, and his flooring; and (c) in an area post transferring is occur the immediate are accordance with N Compressed Gas 1. Based on of interview, the ensure 1 of 1 of storage/transfer or concrete flooring.	is mechanically ventilated, as ceramic or concrete ed with signs indicating that turring, and that smoking in a is not permitted in IFPA 99 and the Association. 8.6.2.5.2 bservation and facility failed to oxygen er areas had ceramic oring. This deficient is all occupants for visitors and	K0143	K143 - The facility will ensuthat oxygen is stored in an a with continuous mechanical ventilation. Oxygen has been moved to a storage area out The facility has been reviewen ensure proper storage of oxyon other hazardous material Monitoring of storage will be conducted at least weekly by Director of Environmental Services or designee. The results of the audits will be	en eside. ed to ygen s.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICAT		IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLETED	
		155752	B. WIN			10/03/2011	
<u> </u>			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					BAILEY AVE		
MORNIN	GSIDE NURSING A	AND MEMORY CARE CENTER		1	I BEND, IN46637		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENCY)	DATE	
	Based on obse at 3:20 p.m. w supervisor, the storage/transfe signage as tranfour liquid oxy had a floor covinstead of ceramaintenance stacknowledged vinyl tiling. 3.1-19(b) 2. Based on of interview, the ensure 1 of 11 storage/transfe with continuous ventilation. To could affect revisitors in and storage room.	ervation on 10/03/11 ith the maintenance e oxygen er room identified by asfer area contained ygen containers and vered with vinyl tiles amic or concrete. The upervisor the flooring was bservation and facility failed to iquid oxygen er areas was provided as mechanical this deficient practice sidents, staff and near the oxygen				hly	
	Findings include:						
	Based on obse	ervation with the upervisor on					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155752	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 01	(X3) DATE COMPI 10/03/2	LETED
NAME OF PROVIDER OR SUPPLIER MORNINGSIDE NURSING AND MEMORY CARE CENTER			p. wind	STREET A	ADDRESS, CITY, STATE, ZIP CODE BAILEY AVE I BEND, IN46637	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
		20 p.m., the oxygen					
ı	_	dentified by signage ransfer area was not					
	provided with						
ı	_	ntilation system. The					
	venting mecha	nism was operated					
		the room. The					
		upervisor stated at					
		servation the existing ated by a switch and					
	not continuous	•					
	3.1-19(b)						
	3. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen supply storage						
	rooms was sep	parated by					
		rith a one hour fire					
	_	g. This deficient					
	practice affects residents, staff and visitors in and near the oxygen						
	storage room.	nom the oxygen					
	-						
	Findings inclu	de:					
	of the facility	rvation during a tour with the maintenance 10/03/11 at 3:20 p.m.,					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155752		(X2) MULTIPLE CO A. BUILDING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/03/2011	
		100702	B. WING	ADDRESS, CITY, STATE, ZIP CODE	10/03/2011
NAME OF PROVIDER OR SUPPLIER				BAILEY AVE	
		AND MEMORY CARE CENTER		I BEND, IN46637	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE DATE
	four liquid oxy	gen supply canisters			
	were stored in	oxygen			
	storage/transfe	er room which had a			
	_	g it as an oxygen			
	transfer area.	The door to the room			
	separating the	area from the			
		orridor did not have			
	_	5 minute fire rating.			
	The door did n				
	_	door's rating and the			
	*	documentation to			
	verify the fire				
		upervisor stated at			
	the time of the	observation, he was			
	not aware of the	ne requirement.			
	3.1-19(b)				